DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/09/2007
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {W 000} | INITIAL COMMENTS<br><br>This recertification survey was conducted from May 22, through May 24, 2007. The survey was initiated using the fundamental survey process; however, it was determined that an extended process should be implemented under the conditions level of participation of client protection and active treatment. Based on the findings of the extended survey a full survey was implemented to review governing body and staffing. A random sample of three clients was initially selected from a residential population of six females. An additional client was added to the sample as a focus. All clients in the sample had diagnoses of profound mental retardation. One of the six clients was blind. Three clients in the facility had psychiatric diagnoses for which medications were prescribed. The clients in this facility had limited to no skills in verbal communications.<br><br>The findings of this survey were based on observations at the facility and day programs ,staff interviews at both the facility and day programs, review of clinical, medical, and administrative records to include the facility's unusual incident reports and policies.<br><br>As a result of the survey findings it was determined that the facility was not in compliance at the Condition Level of Participation under Client Protection.<br><br>**********<br>**********<br><br>The HRDI Inc., Intermediate Care Facility is in compliance with 42 CFR Part 483, Subpart 1, | {W 000} | | |

RECEIVED
DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION
2007 JUL 20 P 3:34

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {W 000} | Continued From page 1<br>requirements for Intermediate Care Facilities in the Conditions of Governing Body and Client Protections. Standard level deficiencies are noted in Active Treatment Services and Health Care Services. A re-survey visit was conducted on July 5, 2007. This survey process focused on verifying compliance with federal and state requirements in the Conditions of Governing Body and Management and Client Protections. Six females with varying degrees of disabilities reside in this facility. The survey sample was derived from a random sampling of three of the six clients. The survey findings are based on observations in the group home. In addition, the findings are based on interviews with residential, nursing and administrative staff. Review of records; including investigations of unusual incidents was also conducted. | {W 000} | | |
| {W 159} | 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL<br><br>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, staff interview and record review, the facility Qualified Mental Retardation Professional (QMRP), failed to adequately monitor, integrate and coordinate each client's health and safety.<br><br>The findings include:<br><br>1. Clients #1, #2, #3 and #4 have several new consultants that started in January 2007. There was no evidence that the consultants who signed contracts had reviewed the needs of the clients or | {W 159} | W159<br><br>1. QMRP has received assessments from consultants: Speech, OT, PT Nutrition and Psychologist regarding Individual Program Plan goals to provide ongoing active treatment to clients. QMRP has been in-serviced on obtaining assessments for clients from consultants and having consultants review client needs on a quarterly/ as needed basis. | 7/19/07 & Ongoing |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {W 159} | Continued From page 2<br>delivered any services to ensure that the actions of the staff in providing active treatment services were appropriate. The professional contracts were reviewed on May 24, 2007 at 12:50 PM. [See W234, W249, W255, and W257]<br><br>2. The QMRP failed to ensure that incident management policies and procedures were implemented to ensure the timely reporting and investigation of unusual incidents. [See W149]<br><br>3. The QMRP failed to ensure sufficient direct care staff to manage and supervise clients while being transported. [See W186]<br><br>4. The QMRP failed to ensure that each employee had been provided with adequate training that enables the employees to perform his or her duties effectively, efficiently and competently. [See W189]<br><br>5. The QMRP failed to ensure that clients who was receiving psychotropic medications had a psychiatric assessment . [See W212]<br><br>6. The QMRP failed to ensure program which incorporate restrictive techniques and use of behavior modification were conducted only with written informed consent. [See W262 and W263]<br><br>7. The QMRP failed to ensure that the clients recommended equipment had been maintained and functional for use. [See W436]<br><br>8. Following the dinner meal observed on May 22, 2007 at approximately 6:20 PM, client #2 was observed to put saliva and chewed food particles in her hand and rub it across her hair and on | {W 159} | 2. QMRP as well as all HRDI management staff has been in-serviced on the Incident Management Policy which was revised during survey process to align with federal regulations which stipulates reporting of all unusual incidents that involve or compromise the health, welfare and safety of the clients.<br><br>3. HRDI has instituted a Transportation policy which stipulates that no one staff should transport any client alone in agency vehicles. In this way the facility can ensure the safety of clients while transporting them in agency vehicles; ensuring staffing provisions so that clients can be supervised and appropriately managed on the vehicles.<br><br>4. QMRP has in-serviced all direct care staff working in the facility on all IPP goals and needs of the clients. QMRP will hold quarterly in-service trainings with the staff to ensure they understand the needs and supports required to serve the clients in the facility. Competency based training and Quality Assurance reviews will also be conducted by Quality Improvement Specialist to ensure competency and quality of services delivered to clients.<br><br>5. QMRP, with the Nurse have scheduled psychiatric assessments for clients in the facility who receive psychotropic medications. Furthermore, the QMRP will ensure that each client prescribed psychotropic medications has a psychiatric evaluation in place. The psychiatrist has evaluated Clients #3 and #4 for restrictive medications being administered.<br><br>6. QMRP has consulted with guardians of individuals to obtain written informed consent concerning the use of restrictive techniques: Behavior Support Plan, psychotropic medications, etc. Those clients that have restrictive techniques incorporated into their IPP will have consents signed annually at their ISP meetings whereby the IDT can explain risks, benefits, etc. to guardians/family members concerning these techniques. (W436) | 5/1/07 & Ongoing<br><br>7/5/07 & Ongoing<br><br>7/19/07 & Ongoing<br><br>7/19/07 & Ongoing<br><br>7/19/07 & Ongoing |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {W 159} | Continued From page 3<br>others who may have been in her immediate surroundings. Client #2 was blind and her actions did not appear to be targeted at any one person. There was no behavioral support plan on file. After being informed that a plan was not located in the file, neither the QMRP nor the House Manager could locate a copy of the Behavioral Support Plan (BSP).<br><br>A review of clinical records was conducted on May 24, 2007 at 12:35 PM, and a document that reflected "BSP review" dated April 20, 2005 was identified. The document reflected that the plan was to address self stimulation behaviors. "The strategies described in the BSP of April 2004 continues to appropriately address these strategies will remain in place."<br><br>It could not be determined that Client #2's BSP plan had been reviewed in two years. There was no BSP available during the survey period. Interviews on May 22, 2007 with day program and facility direct care staff, revealed that the Client's behaviors of wetting her hand and putting the elements over her face and head continues to occur. According to the staff, they were not provided directions to address the behaviors. According to the documentation reviewed on May 23, 2007 at 4:55 PM, client #2 had exhibited the behavior 21 times from May 1 to May 22, 2007.<br><br>9. Refer to W255 and W257. The QMRP failed to ensure consistent opporutnities for clients to learn and enhance skills.<br><br>10. Refer to W249. The QMRP failed to ensure that clients were provided the opportunities for continuous active treatment in accordance with their individual program plans (IPPs). | {W 159} | 7. QMRP has been in-serviced on the maintenance and upkeep of all client adaptive equipment. As well there will be daily adaptive equipment checklist to be completed by staff and management to ensure adaptive equipment is in good repair. All staff and home manager have been trained on completing the Adaptive equipment Checklist which is filed in each clients record with their individualized adaptive equipment listed on the form. | 7/16/07 |
| | | | 8. Client #2 has, since survey, been assessed by the psychologist whom instituted a BSP to address self stimulatory behaviors. QMRP, Home Manager and facility direct care staff have been in-serviced on the proper interventions to be provided when Client #2 engages in elf stimulatory behaviors. In addition psychologist will conduct quarterly reviews of BSP and provide in-service training to staff as needed. | 7/5/07 & Ongoing |
| | | | (W255, W257)<br>9. QMRP and Home Manager have been in-serviced on ensuring quality services are delivered to all clients via IPP goals and objectives as well as community integration opportunities. Home Manager has developed a quarterly activity schedule with recreation calendar that offers alternative activities. | 7/5/07 & Ongoing |
| | | | (W249)<br>10. QMRP has been in-serviced on IPP development and will ensure that all clients ISP/IPP will begin as soon as determined by the IDT (at time of ISP) such that active treatment is continuous and needed program interventions are implemented immediately. | 7/5/07 & Ongoing |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {W 159} | Continued From page 4<br><br>10. The Qualified Mental Retardation Professional (QMRP) failed to ensure that training programs included methodology for staff implementation. Refer to W234<br><br>**********<br>**********<br><br>Based on observation, staff interview and record review, the facility Qualified Mental Retardation Professional (QMRP), failed to adequately monitor, integrate and coordinate each client's health and safety.<br><br>The findings include:<br><br>1. Cross refer to W436. The QMRP failed to ensure that the clients recommended equipment had been maintained and functional for use.<br><br>2. Cross refer to W249. The QMRP failed to ensure that clients were provided the opportunities for continuous active treatment in accordance with their individual program plans (IPPs). | {W 159} | (W436)<br>1. QMRP has been in-serviced on the maintenance and upkeep of all client adaptive equipment. As well there will be daily adaptive equipment checklist to be completed by staff and management to ensure adaptive equipment is in good repair. All staff and home manager have been trained on completing the Adaptive equipment Checklist which is filed in each clients record with their individualized adaptive equipment listed on the form. | 7/19/07 & Ongoing |
| {W 249} | 483.440(d)(1) PROGRAM IMPLEMENTATION<br><br>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. | {W 249 | (W249)<br>2. ISP/IPP will begin as soon as determined by the IDT (at time of ISP) such that active treatment is continuous and needed program interventions are implemented immediately. | 7/16/07 & Ongoing |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {W 249} | Continued From page 5<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, staff interviews and record review, the facility failed to ensure that clients were provided the opportunities for continuous active treatment in accordance with their individual program plans (IPPs).<br><br>The findings include:<br><br>1. Client #2's IPPs, documentation, and clinical records were reviewed on May 24, 2007 at 11:40 AM.<br><br>According to client #2's IPP, the client had a program that read "will improve expressive language skills by using the sign eat for 80% of the opportunities with hand/hand. Observations of snack times were made on May 22, and 23, 2007 at approximately 4:15 PM each day and a dinner meal on May 22, 2007 at approximately 6:10 PM. There were no attempts observed to have client #2 to sign eat at the given opportunities.<br><br>2. During the observation period on May 22, 2007, client #2 was observed to be visually impaired. The House Manager confirmed that client #2 was blind. This diagnosis was also included on the Medical assessment dated January 23, 2007 that was reviewed on May 22, 2007 at 6:00 PM.<br><br>The psychological assessment dated January 2007 that was reviewed on May 23, 2007 at 3:45 PM reflected that the client should be encouraged to participate in sensory activities including sound, smell, tast, and touch. Further stated was the "it would be helpful to tailor activities around her | {W 249} | (W249)<br>1. Client #2 has received Speech assessment to identify the need for a communication goal. Direct care staff, Home Manager and QMRP have been in-serviced on communication goal for Client #2 to sign "eat" at appropriate times (during mealtime). As an assurance QMRP/SLP will ensure staff are trained/in-serviced quarterly on communication goals.<br><br>2. Client #2's IPP goals and objectives have been revised to reflect activities that engage her in sensory stimulatory activities. Staff have been in-serviced on self stimulatory activities that engage her in activities that indulge her senses besides sight as she is visually impaired. | 7/5/07<br><br>7/5/07 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {W 249} | Continued From page 6<br>senses".<br><br>On May 23, 2007 at 4:03 AM, the House Manager indicated that sensory motor equipment was in the facility. The equipment shown included a sensi- ball switch, vibrating mini bubbles, gooshy switch, oval tax multi sensory, and high music vibration enabling device. These items were inoperable perhaps due to having no batteries.<br><br>Although music played while all clients were sitting out on their porch, this was the only sensory motor functioning activity provided during the observation. It could not be determined that client #2 had been engaged in the multiple sensory task/activities as recommended.<br><br>3. Client #2's IPP and data was reviewed on May 24, 2007 at approximately 11:00 AM.<br><br>a. Client #2 had an objective which read "will participate in an activity with her peers or staff with verbal assistance". The focus of the program was identified to be "setting the table". There was no opportunity offered or attempted during May 22, 2007 dinner meal or the snack times on May 22 and 23, 2007. The documentation that was reviewed reflected that the client had performed at 0% since January 2007.<br><br>b. Client #2's had an objective to "stack utensils on top of her plate ". There was no opportunity offered or attempted during May 22, 2007 dinner meal or the snack times on May 22 and 23, 2007.<br><br>********** | {W 249} | 3. a)<br><br>QMRP has revised Client #2's goal which states "will participate in an activity with peers or staff with verbal assistance" to reflect that Client#2 actually engages in an activity with peers as a socialization goal (i.e. choose an activity to participate in of her choice).<br>b) QMRP has in-serviced direct care staff in the facility on all clients IPP goals and objectives. Client #2's goal "stack utensils on top of her plate" will be conducted during natural opportunities such that the habilitative goal is implemented. | 7/5/07 & ongoing |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {W 249} | Continued From page 7<br><br>Based on observation, staff interviews and record review, the facility failed to ensure that clients were provided the opportunities for continuous active treatment in accordance with their individual program plans (IPPs).<br><br>The finding includes:<br><br>On July 5, 2007 at 1:35 PM, the House Manager indicated that the sensory motor equipment in the facility did not contain batteries. Interview with the Quality Assurance Director on July 5, 2007 at approximately 2:00 PM revealed that the facility was ordering new sensory motor equipment along with batteries on July 5, 2007. There was no evidence that Client #2 had been engaged in the multiple sensory task/activities as recommended by the psychologist. | {W 249} | | |
| {W 322} | 483.460(a)(3) PHYSICIAN SERVICES<br><br>The facility must provide or obtain preventive and general medical care.<br><br>This STANDARD is not met as evidenced by:<br>Based on medical record review, the facility failed to ensure medical preventive and general medical care through timely appointments and follow up for two of three clients in the primary sample.<br><br>The finding includes:<br><br>1. On May 22, 2007, between 2:05 PM and 4:00 PM, client #1's medical records were reviewed. The medical assessment dated September 19, 2006 reflected the following medical | {W 322} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {W 322} | Continued From page 8<br>recommendation procedures were not completed timely as evidence below:<br><br>a. According to a GYN consultation dated July 11, 2006, client #1 allowed a small sample obtained for the culture since the client "did not allow brushing of the cervix". The document reflected that if the sample was not adequate then the procedure would need to be repeated. Prior to this examination, another exam had been attempted March 2005; however, it was unsuccessful. The primary physician's note dated August 16, 2006 reviewed at 3:48 PM reflected "annual exam, pap done, results pending". At the time of the survey, the result were not available and the physician had not made further reference to the results in follow up monthly notes.<br><br>b. According to client #1's mammogram report dated March 27, 2006, the client was to have a return visit in twelve months. At the time of the survey, the annual mammogram had not been done. The surveyor the Registered Nurse (RN) discussed the appointment. On May 24, 2007, at 11:30 AM, the RN informed the surveyor that client #1 was not seen at the time that the other clients received their mammograms because the LPN was told that client #1 required a diagnostic mammogram. The RN scheduled the exam at the time of survey for June 11, 2007.<br><br>The facility failed to ensure that client #1 received a timely diagnostic mammogram as recommended. It should be mentioned that the facility medical staff conducts quarterly breast examinations and documents the findings.<br><br>c. According to client #1's ENT report reviewed at 3:55 PM, client #1 was seen August 7, 2006 | {W 322} | (W322)<br>1)<br>a) Nurse has obtained results from Client #1's GYN consultation held on July 11, 2006. The Nurse will ensure that all results are obtained from consultations in a timely manner.<br><br>b) The facility Nurse has scheduled Client#1 for mammogram for June 11, 2007 and will ensure that all recommended consultations are conducted within a specific timeframe which does not interfere with the client's health, safety and welfare.<br><br>c) Nurse has been in-serviced on providing adequate follow-up care to all clients in the home specifically Client #1 has been scheduled for follow up visit for ENT/ BSER evaluation.<br><br>d) Nurse has been in-serviced on providing follow-up and making required notations per recommended consultations. EKG results for Client #1 have been obtained and notations made in Client #1's medical record. As a practice, HRDI Nurse's will ensure that record keeping is maintained and client records reflect results and any follow-up recommendations are completed. | 7/11/07 & annually<br><br>7/11/07 & annually<br><br>7/5/07 & Ongoing<br><br>7/5/07 & Ongoing |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {W 322} | Continued From page 9<br>and had the right ear wax removed and the left ear wax was partially removed. Debrox for the left ear wax prescribed for one month prior to follow up. There were further instructions to follow up in six months to one year and then have the audiological performed.<br><br>Client #1 was seen by the audiologist for a (Brainstem Response) BSER on October 31, 2006. The client was diagnosed with excessive cerumen in the left ear. The facility was requested to not return the client until the ears are cleared.<br><br>The nursing staff failed to follow through on the ENT return visit recommendations prior to attempting the BSER.<br><br>d. According to the primary physician's notation on an August 7, 2006's consultation document, client #1 had a diagnosis of hypertension. Also noted by the primary physician was that client #1 had an EKG conducted and that the report was to follow. The surveyor and the RN attempted to locate the results of the EKG on May 25, 2007 at 11:53 AM. The report was not available at the facility. There were no follow up notations about the EKG identified in the following months of summaries by the primary physician.<br><br>2. The facility failed to provide safe techniques to encourage clients #1 and #3 from consuming foods in a fast pace.<br><br>a). Client #1 was observed having dinner on May 22, 2007 at approximately 6:08 PM. The surveyor was standing approximately twelve inches from the table where all clients were seated. Within fifteen to twenty seconds, client #1 had consumed all of her food. There was no intervention | {W 322} | 2)<br>a) Direct care staff have been in-serviced on eating paces for Client #1 per the SLP instructional plan for slowing her eating pace. Eating Guidelines have been developed for clients in the home. QMRP will ensure that SLP and Nutritionist conduct quarterly reviews to ensure that eating guidelines/protocols address the client's needs.<br><br>b) Direct care staff have been in-serviced on eating paces for Client #3 per the SLP instructional plan for slowing her eating pace. Eating Guidelines have been developed for clients in the home. QMRP will ensure that SLP and Nutritionist conduct quarterly reviews to ensure that eating guidelines/protocols address the client's needs. | 7/16/07 & Ongoing<br><br>7/16/07 & Ongoing |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {W 322} | Continued From page 10<br>observed or overheard.<br><br>An interview with client #1's lead day program staff was conducted on May 22, 2007 at 11:20 AM. This interview revealed that client #1 was capable of eating independently; however, the client was monitored to slow down. The client was also prescribed a chopped diet.<br><br>On May 23, 2007 at approximately 9:00 AM, the surveyor inquired as to rather client #1 had any guidelines for eating as part of her meal plan.<br><br>A speech report dated November 13, 2006 was reviewed on May 23, 2006 at 9:00 AM. This report reflected "home should continue to use guidelines to promote slow eating rate". Another report noted by speech and dated June 8, 2006 reflected "follow eating and texture guidelines per the speech therapist. A document identified in client #1's training book reflected "pace by using attached slow eating rate protocol". There was no attached protocol.<br><br>It could not be determined that client #1's rapid eating pace had been addressed through a formal and consistent protocol to prevent possible choking.<br><br>b). During observations of the the dinner meal conducted on May 22, 2007 beginning at 6:24 PM, Client #3 was observed eating her dinner meal. The client was observed eating very rapidly while staff supervised the table. Interview with the staff #1 on the same day at approximately 7:15 PM indicated that Client #3 eats very fast and has to be prompted to slow down.<br><br>Review of the Speech and Language Assessment | {W 322} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {W 322} | Continued From page 11<br>dated 11/13/06 on 5/23/07 at 11:12 AM revealed a feeding/swallowing protocol. The protocol indicated that "staff should continue to provide for Client #3 by adhering to the attached form to slow eating pace, as she can utilize an acceleration eating pace at times." Further review of Client #3's Nutritional Assessment dated 12/8/06 on the same day at approximately 11:25 AM revealed under the "Nutrition Conditions" Potential for aspiration.<br><br>Review of the in service training log on 5/24/07 at approximately 12:30 PM revealed that staff had been trained on aspiration on 5/17/06. There was no evidence that training was effective. The facility failed to followed the feeding/swallowing protocol as recommended by the Speech and Language Pathologist.<br><br>Note: The medical assessment date September 19, 2006 reflected diagnoses to include hypertension and history of carcinoma of left breast, left breast mastectomy.<br><br>**********<br>**********<br><br>Based on medical record review, the facility failed to ensure medical preventive and general medical care through timely appointments and follow up for two of three clients in the primary sample. (Client #1 and Client # 3)<br><br>The finding includes:<br><br>1. Interview with the Licensed Practical Nurse (LPN) on June 5, 2007, at approximately 1:45 PM revealed that the results of Client #1's annual pap | {W 322} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {W 322} | Continued From page 12<br>exam dated July 11, 2006 had not been obtained. There was no documented evidence that the facility had obtained the client's pap exam results.<br><br>2. Interview with the Licensed Practical Nurse (LPN) on June 5, 2007, at approximately 1:15 PM revealed that Direct Care Staff #1 had not been provided training in detecting the signs and symptoms of aspiration. There was no documented evidence that the nursing staff had provided training in the detecting signs and symptoms of aspiration for Direct Care Staff #1. | {W 322} | | |
| {W 342} | 483.460(c)(5)(iii) NURSING SERVICES<br><br>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interviews, and the review of training records the facility's nursing services failed to ensure that the direct care staff had been provided training in detecting signs and symptoms of illness or dysfunction for one of four clients in the sample.<br><br>The finding includes:<br><br>Client #1 was observed having dinner on May 22, 2007 at approximately 6:08 PM. The surveyor was standing approximately twelve inches from the table where all clients were seated. Within fifteen to twenty seconds, client #1 had consumed | {W 342} | (W342)<br>1. LPN/Nurse has obtained Client #1's annual pap conducted on June 11, 2006. Nurse has been in-serviced on obtaining results from exams/ consultations in a timely manner. 7/5/07<br><br>2. LPN/Nurse Coordinator has in-serviced all direct care staff in the facility on signs and symptoms of illness (i.e. aspiration, Health Management Care Plan). As well, Quality Improvement specialist will conduct monthly trainings which include Signs and Symptoms of illness such that direct care staff can be sent to trainings to ensure comprehension of training. 7/5/07 & Ongoing | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {W 342} | Continued From page 13<br>all of her food. There was no intervention observed or overheard.<br><br>Based on staff performance during the dinner meal, it could not be determined that the direct care staff, overseeing client #1's meal, had been trained to address client #1's rapid eating pace and potential for aspiration.<br><br>The training record reviewed on May 24, 2007 at approximately 11:30 PM reflected that out of nine direct care staff three direct care staff had received training on May 17, 2006 on detection of signs and symptoms of aspiration. There were no current trained direct care staff.<br><br>**********<br><br>Based on observation, interviews, and the review of training records the facility's nursing services failed to ensure that the direct care staff had been provided training in detecting signs and symptoms of illness or dysfunction for two of three clients in the primary sample. (Client #1 and Client #3)<br><br>The finding includes:<br><br>Interview with the Licensed Practical Nurse (LPN) on June 5, 2007, at approximately 1:15 PM revealed that Direct Care Staff #1 had not been provided training in detecting the signs and symptoms of aspiration. There was no documented evidence that the nursing staff had provided training in the detecting signs and symptoms of aspiration for Direct Care Staff #1. | {W 342} | | |
| {W 436} | 483.470(g)(2) SPACE AND EQUIPMENT | {W 436} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {W 436} | Continued From page 14<br>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure that clients were provided with necessary adaptive equipment, for two of four clients included in the sample. (Client #2, #4)<br><br>The findings include:<br><br>The facility failed to ensure that Clients#2 and #4 stimulation tools was maintained and in good repair.<br><br>1. Observations and attempts to interview the Client#4 revealed that the client was non verbal. Review of Client #4's habilitation records on 5/24/07 at approximately 3:50 PM revealed Psychological Assessment dated 11/30/06. The assessment documented that given the following recommendations, "Promote use of sensory stimulations tools and exploration of her environment through touch and smell". Interview with the House Manager on 5/23/06 at 4:03 PM revealed that Client #4 has several sensory stimulations tools. When asked to see the stimulation tools, the house manager presented the surveyor with a sensi- ball switch, vibrating mini bubbles, the gooshy switch, oval tax multi sensory, and high music vibration enabling device all of which required batteries. Further interview | {W 436} | (W436)<br>1. Home Manager has been in-serviced on Client #4's sensory stimulation tools maintenance and repair pertaining to keeping adaptive equipment in good repair. In addition, the management staff and direct care staff have been in-serviced on the Adaptive Equipment Checklist to be completed daily by staff. | 7/5/07 & Ongoing |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {W 436} | Continued From page 15<br>with the house manager revealed that tools have been without operating batteries for over a month. Therefore, the stimulation tools was not available for the client's use.<br><br>2. The facility failed to provide client #2 with functional sensory stimulation equipment. Refer to W249.<br><br>**********<br>**********<br>Based on observation, interview, and record review, the facility failed to ensure that clients were provided with the necessary adaptive equipment, for two of four clients included in the sample. (Client #2 and Client #4)<br><br>The finding includes:<br><br>On July 5, 2007 at 1:35 PM, the House Manager indicated that the sensory motor equipment in the facility did not contain batteries. Interview with the Quality Assurance Director on July 5, 2007 at approximately 2:00 PM revealed that the facility was ordering new sensory motor equipment along with batteries on July 5, 2007. There was no evidence that Resident #2 and Resident # 4 had been provided with the necessary adaptive equipment to maintain or enhance their functional skill levels. | {W 436} | 2. Home Manager has been in-serviced on Client #2's sensory stimulation tools maintenance and repair pertaining to keeping adaptive equipment in good repair. In addition, the management staff and direct care staff have been in-serviced on the Adaptive Equipment Checklist to be completed daily by staff. | 7/5/07 & Ongoing |

Health Regulation Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {I 000} | INITIAL COMMENTS<br><br>This licensure survey was conducted from May 22, through May 24, 2007. A random sample of three clients was initially selected from a residential population of six females. An additional client was added to the sample as a focus. All clients in the sample had diagnoses of profound mental retardation. Two of the clients had diagnosis of blindness and three clients had psychiatric diagnoses for which medications were prescribed. The consumers in this facility had limited to no skills in verbal communications.<br><br>The findings of this survey based on observations at the facility and day programs ,staff interviews at both the facility and day programs, review of clinical, medical, and administrative records to include the facility's unusual incident reports and policies.<br><br>**********<br>**********<br><br>The HRDI Inc., Intermediate Care Facility is in compliance with 42 CFR Part 483, Subpart 1, requirements for Intermediate Care Facilities in the Conditions of Governing Body and Client Protections. Standard level deficiencies are noted in Active Treatment Services and Health Care Services. A re-survey visit was conducted on July 5, 2007. This survey process focused on verifying compliance with federal and state requirements in the Conditions of Governing Body and Management and Client Protections. Six females with varying degrees of disabilities reside in this facility. The survey sample was derived from a random sampling of three of the six residents. The survey findings are based on observations in the group home. In addition, the | {I 000} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {I 000} | Continued From page 1<br>findings are based on interviews with residential, nursing and administrative staff. Review of records; including investigations of unusual incidents was also conducted. | {I 000} | | |
| {I 052} | 3502.10 MEAL SERVICE / DINING AREAS<br><br>Each GHMRP shall equip dining areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each resident.<br><br>This Statute is not met as evidenced by:<br>The findings include:<br><br>During the dinner observation conducted on May 22, 2007 at approximately 6:20 PM, all clients were provided with spoons to eat with. There was no encouragement for clients to utilize other utensils as appropriate. Clients #1 and #2's habilitation reports did not reflect that these clients were incapable of using or learning to use utensils other than spoons.<br><br>**********<br>**********<br><br>The finding includes:<br><br>Observation of the dinner meal on July 5, 2007 at approximately 6:15 PM revealed that all of the clients were only provided spoons to eat with during mealtime. There was no encouragement for the residents to utilize other utensils as appropriate. Resident #1 and Resident #2's habilitation reports did not reflect that these residents were incapable of using or learning to use utensils other than spoons. | {I 052} | I052<br>QMRP, with OT has reviewed and assessed Resident #1 and Resident #2 habilitation report to include alternating use of other utensils besides spoons. QMRP and Occupational Therapist will review client needs quarterly regarding using eating utensils during mealtimes. All staff have been in-serviced on encouraging residents to use other eating utensils unless otherwise indicated through assessment during mealtimes. QMRP and Home Manager will conduct weekly mealtime observations to assess residents' capabilities in using either eating utensils besides spoons. | 7/17/07 & Ongoing |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {I 090} | Continued From page 2 | {I 090} | | |
| {I 090} | 3504.1 HOUSEKEEPING<br><br>The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.<br><br>This Statute is not met as evidenced by:<br>The findings include:<br><br>During the environmental inspection on May 24, 2007 at 9:35 AM, the surveyor recognized that excessive molding was found on the window ceil and around the window casing of the second floor bathroom.<br><br>**********<br>**********<br><br>The finding includes:<br><br>During the environmental inspection on July 5, 2007 at approximately 10:00 AM it was revealed that excessive mold was still present around the window casing of the second floor bathroom. Interview with the House Manager on July 5, 2007 at approximately revealed that the maintenance employees had not removed the mold around the window casing of the second floor bathroom. There was no documented evidence that a work order had been submitted for the maintenance employees to remove the mold around the window casing of the second floor bathroom. | {I 090} | I090<br>Home Manager has submitted work order to have mold removed from second floor bathroom. As an assurance, all home managers have a Maintenance Checklist that is conducted weekly, monthly as well as a daily walk-through is performed for maintenance issues in all facilities. | 7/5/07 |
| {I 209} | 3509.9(a) PERSONNEL POLICIES | {I 209} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {I 209} | Continued From page 3<br>Each GHMRP shall obtain employment references on each employee and no GHMRP shall employ an individual who has a history of the following:<br><br>(a) Child or resident abuse or abuse of someone under his or her care and supervision;<br><br>This Statute is not met as evidenced by:<br>The findings include:<br><br>Personnel records were reviewed on May 24, 2007 at 9:50 AM. Three staff files were not made available for review. Three other staff files did not containe police clearences.<br><br>**********<br>**********<br><br>The finding include:<br><br>Interview and record review on July 5, 2007 at approximately 12:00PM revealed no documented evidence of three staff files and their police clearences. | {I 209} | I209<br>HRDI Human Resources Administrator has conducted complete background checks to include past 7 years of where the employees lived or worked. All background checks will be conducted before employees are placed in any HRDI facility to include "child or resident abuse or abuse of someone under his or her care and supervision". | 7/17/07 & Ongoing |
| {I 210} | 3509.9(b) PERSONNEL POLICIES<br><br>Each GHMRP shall obtain employment references on each employee and no GHMRP shall employ an individual who has a history of the following:<br><br>(b) Neglect;<br><br>This Statute is not met as evidenced by:<br>The findings include:<br><br>Personnel records were reviewed on May 24, 2007 at 9:50 AM. Three staff files were not made | {I 210} | I210<br>HRDI Human Resources Administrator has conducted complete background checks to include past 7 years of where the employees lived or worked. All background checks will be conducted before employees are placed in any HRDI facility to include "neglect". | 7/17/07 & Ongoing |

Health Regulation Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {I 210} | Continued From page 4<br>available for review. Three other staff files did not containe police clearences.<br>**********<br>The finding include:<br>Interview and record review on July 5, 2007 at approximately 12:00PM revealed no documented evidence of three staff files and their police clearences. | {I 210} | | |
| {I 211} | 3509.9(c) PERSONNEL POLICIES<br>Each GHMRP shall obtain employment references on each employee and no GHMRP shall employ an individual who has a history of the following:<br>(c) Exploitation; or...<br>This Statute is not met as evidenced by:<br>The findings include:<br>Personnel records were reviewed on May 24, 2007 at 9:50 AM. Three staff files were not made available for review. Three other staff files did not contain police clearences.<br>**********<br>The finding include:<br>Interview and record review on July 5, 2007 at approximately 12:00PM revealed no documented evidence of three staff files and their police clearences. | {I 211} | I211<br>HRDI Human Resources Administrator has conducted complete background checks to include past 7 years of where the employees lived or worked. All background checks will be conducted before employees are placed in any HRDI facility to include "exploitation...". | 7/17/07 & Ongoing |

Health Regulation Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {I 212} | Continued From page 5 | {I 212} | | |
| {I 212} | 3509.9(d) PERSONNEL POLICIES<br><br>Each GHMRP shall obtain employment references on each employee and no GHMRP shall employ an individual who has a history of the following:<br><br>(d) Conviction for a sexual offense or violent crime.<br><br>This Statute is not met as evidenced by:<br>The findings include:<br><br>Personnel records were reviewed on May 24, 2007 at 9:50 AM. Three staff files were not made available for review. Three other staff files did not containe police clearences.<br><br>**********<br>**********<br><br>The finding include:<br><br>Interview and record review on July 5, 2007 at approximately 12:00PM revealed no documented evidence of three staff files and their police clearences. | {I 212} | I212<br>HRDI Human Resources Administrator has conducted complete background checks to include past 7 years of where the employees lived or worked. All background checks will be conducted before employees are placed in any HRDI facility to include "conviction for a sexual offense or violent crime". | 7/17/07 & Ongoing |
| {I 391} | 3520.2(a) PROFESSION SERVICES: GENERAL PROVISIONS<br><br>Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be | {I 391} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {I 391} | Continued From page 6<br>necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services:<br><br>(a) Medicine;<br><br>This Statute is not met as evidenced by:<br>The findings:<br><br>1. On May 22, 2007, between 2:05 PM and 4:00 PM, client #1's medical records were reviewed. The medical assessment date September 19, 2006 reflected diagnoses to include hypertension and history of carcinoma of left breast, left breast mastectomy.<br><br>a. According to a GYN consultation dated July 11, 2006, client #1 allowed a small sample obtained for the culture since the client "did not allow brushing of the cervix". The document reflected that if the sample was not adequate then the procedure would need to be repeated. Prior to this examination, another exam had been attempted March 2005; however, it was unsuccessful. The primary physician's note dated August 16, 2006 reviewed at 3:48 PM reflected "annual exam, pap done, results pending". At the time of the survey, the result were not available and the physician had not made further reference to the results in follow up monthly notes.<br><br>b. According to client #1's mammogram report dated March 27, 2006, the client was to have a return visit in twelve months. At the time of the survey, the annual mammogram had not been done. The surveyor and Registered Nurse (RN) | {I 391} | I391<br>1. a) Nurse has obtained results from Client #1's GYN consultation held on July 11, 2006. The Nurse will ensure that all results are obtained from consultations in a timely manner.<br><br>b) The facility Nurse has scheduled Client#1 for mammogram for June 11, 2007 and will ensure that all recommended consultations are conducted within a specific timeframe which does not interfere with the client's health, safety and welfare. | 7/5/07<br><br>7/11/07 & Ongoing |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {I 391} | Continued From page 7<br>discussed the appointment. On May 24, 2007, at 11:30 AM, the RN informed the surveyor that client #1 was not seen at the time that the other clients received their mammograms because the LPN was told that client #1 required a diagnostic mammogram. The RN scheduled the exam at the time of survey for June 11, 2007.<br><br>The facility failed to ensure that client #1 received a timely diagnostic mammogram as recommended. It should be mentioned that the facility medical staff conducts quarterly breast examinations and documents the findings.<br><br>c. According to client #1's ENT report reviewed at 3:55 PM, client #1 was seen August 7, 2006 and had the right ear wax removed and the left ear wax was partially removed. Debrox for the left ear wax prescribed for one month prior to follow up. There were further instructions to follow up in six months to one year and then have the audiological performed.<br><br>Client #1 was seen by the audiologist for a (Brainstem Response) BSER on October 31, 2006. The client was diagnosed with excessive cerumen in the left ear. The facility was requested to not return the client until the ears are cleared.<br><br>The nursing staff failed to follow through on the ENT return visit recommendations prior to attempting the BSER.<br><br>d. According to the primary physician's notation on an August 7, 2006's consultation document, client #1 had a diagnosis of hypertension. Also noted by the primary physician was that client #1 had an EKG conducted and that the report was to follow. The surveyor and the RN attempted to | {I 391} | c) Nurse has been in-serviced on providing adequate follow-up care to all clients in the home specifically Client #1 has been scheduled for follow up visit for ENT/ BSER evaluation.<br><br>d) Nurse has been in-serviced on providing follow-up and making required notations per recommended consultations. EKG results for Client #1 have been obtained and notations made in Client #1's medical record. As a practice, HRDI Nurse's will ensure that record keeping is maintained and client records reflect results and any follow-up recommendations are completed | 7/5/07 & Ongoing<br><br>7/5/07 & Ongoing |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {I 391} | Continued From page 8<br>locate the results of the EKG on May 25, 2007 at 11:53 AM. The report was not available at the facility. There were no follow up notations about the EKG identified in the following months of summaries by the primary physician.<br><br>2. The facility failed to provide safe techniques to encourage client #1 from consuming foods in a fast pace.<br><br>Client #1 was observed having dinner on May 22, 2007 at approximately 6:08 PM. The surveyor was standing approximately twelve inches from the table where all clients were seated. Within fifteen to twenty seconds, client #1 had consumed all of her food. There was no intervention observed or overheard.<br><br>An interview with client #1's lead day program staff was conducted on May 22, 2007 at 11:20 AM. This interview revealed that client #1 was capable of eating independently; however, the client was monitored to slow down. The client was also prescribed a chopped diet.<br><br>On May 23, 2007 at approximately 9:00 AM, the surveyor inquired as to rather client #1 had any guidelines for eating as part of her meal plan.<br><br>A speech report dated November 13, 2006 was reviewed on May 23, 2006 at 9:00 AM. This report reflected "home should continue to use guidelines to promote slow eating rate". Another report noted by speech and dated June 8, 2006 reflected "follow eating and texture guidelines per the speech therapist. A document identified in client #1's training book reflected "pace by using attached slow eating rate protocol". There was no attached protocol. | {I 391} | 2. QMRP has, since survey, obtained an assessment from the Speech and Language Pathologist whereby the Eating Guidelines have been implemented. All staff have been in-serviced on eating guidelines which indicate where staff should provide intervention to promote a slower eating pace. SLP and QMRP will ensure quarterly reviews are conducted to assess client needs. | 7/16/07 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {I 391} | Continued From page 9<br>It could not be determined that client #1's rapid eating pace had been addressed through a formal and consistent protocol to prevent possible choking.<br><br>3. During observations of the the dinner meal conducted on May 22, 2007 beginning at 6:24 PM, Client #3 was observed eating her dinner meal. The client was observed eating very rapidly while staff supervised the table. Interview with the staff #1 on the same day at approximately 7:15 PM indicated that Client #3 eats very fast and has to be prompted to slow down.<br><br>Review of the Speech and Language Assessment dated 11/13/06 on 5/23/07 at 11:12 AM revealed a feeding/swallowing protocol. The protocol indicated that "staff should continue to provide for Client #3 by adhering to the attached form to slow eating pace, as she can utilize an acceleration eating pace at times." Further review of Client #3's Nutritional Assessment dated 12/8/06 on the same day at approximately 11:25 AM revealed under the "Nutrition Conditions" Potential for aspiration.<br><br>Review of the in service training log on 5/24/07 at approximately 12:30 PM revealed that staff had been trained on aspiration on 5/17/06. There was no evidence that training was effective. The facility failed to followed the feeding/swallowing protocol as recommended by the Speech and Language Pathologist.<br><br>**********<br>**********<br><br>Based on medical record review, the facility failed to ensure medical preventive and general medical care through timely appointments and | {I 391} | 3. QMRP has, since survey, obtained an assessment from the Speech and Language Pathologist for Client #3 whereby the Eating Guidelines have been implemented to include choking and aspiration prevention plan. All staff have been in-serviced on eating guidelines which indicate where staff should provide intervention to promote a slower eating pace. SLP and QMRP will ensure quarterly reviews are conducted to assess client needs. | 7/16/07 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {I 391} | Continued From page 10<br>follow up for one of three residents in the primary sample. (Resident #1 and Resident #3)<br><br>The findings include:<br><br>1. Interview with the Licensed Practical Nurse (LPN) on June 5, 2007, at approximately 1:45 PM revealed that the results of Resident #1's annual pap exam dated July 11, 2006 had not been obtained. There was no documented evidence that the facility had obtained the client's pap exam results.<br><br>2. Interview with the Licensed Practical Nurse (LPN) on June 5, 2007, at approximately 1:15 PM revealed that Direct Care Staff #1 had not been provided training in detecting the signs and symptoms of aspiration. There was no documented evidence that the nursing staff had provided training in the detecting signs and symptoms of aspiration for Direct Care Staff #1. | {I 391} | I391<br>1. Nurse has obtained results from Client #1's GYN consultation held on July 11, 2006. The Nurse will ensure that all results are obtained from consultations in a timely manner<br><br>2. Nurse has provided in-service training to all staff regarding signs and symptoms of illness. As well Quality Improvement Specialist conducts monthly trainings which include Signs and Symptoms of illness. Nurse in the facility will ensure in-service trainings are conducted quarterly and on an as needed basis such that client care is assured. | 7/5/07<br><br>7/16/07 & Ongoing |
| {I 395} | 3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS<br><br>Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services:<br><br>(e) Nursing;<br><br>This Statute is not met as evidenced by: | {I 395} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {I 395} | Continued From page 11<br>The findings include:<br><br>Refer to "a" 3520.2 state licensing report.<br><br>**********<br>**********<br>Based on medical record review, the facility failed to ensure medical preventive and general medical care through timely appointments and follow up for two of three residents in the primary sample. (Resident#1 and Resident #3)<br><br>The findings include:<br><br>1. Interview with the Licensed Practical Nurse (LPN) on June 5, 2007, at approximately 1:45 PM revealed that the results of Resident #1's annual pap exam dated July 11, 2006 had not been obtained. There was no documented evidence that the facility had obtained the client's pap exam results.<br><br>2. Interview with the Licensed Practical Nurse (LPN) on June 5, 2007, at approximately 1:15 PM revealed that Direct Care Staff #1 had not been provided training in detecting the signs and symptoms of aspiration. There was no documented evidence that the nursing staff had provided training in the detecting signs and symptoms of aspiration for Direct Care Staff #1. | {I 395} | I395<br>Nurse has obtained pap smear results from Residen #1's annual pap test held on June 11, 2006. Nurse ha been in-serviced on obtaining results from consultation and doctor's visits in a timely manner and that such results will be maintained in the residents' medical record. As well the Nurse will make all necessary notations in the medical record to ensure adequate follow-up and communication is available.<br><br>Nurse has provided in-service training to all staff regarding signs and symptoms of illness. As well Quality Improvement Specialist conducts monthly trainings which include Signs and Symptoms of illness. Nurse in the facility will ensure in-service trainings are conducted quarterly and on an as needed basis such that client care is assured. | 7/5/07<br><br>7/16/07 & Ongoing |
| {I 420} | 3521.1 HABILITATION AND TRAINING<br><br>Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. | {I 420} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {I 420} | Continued From page 12<br>This Statute is not met as evidenced by:<br>The findings include:<br><br>1. Client #2's IPPs, documentation, and clinical records were reviewed on May 24, 2007 at 11:40 AM.<br><br>According to client #2's IPP, the client had a program that read "will improve expressive language skills by using the sign eat for 80% of the opportunities with hand/hand. Observations of snack times were made on May 22, and 23, 2007 at approximately 4:15 PM each day and a dinner meal on May 22, 2007 at approximately 6:10 PM. There were no attempts observed to have client #2 to sign eat at the given opportunities.<br><br>2. During the observation period on May 22, 2007, client #2 was observed to be visually impaired. The House Manager confirmed that client #2 was blind. This diagnosis was also included on the Medical assessment dated January 23, 2007 that was reviewed on May 22, 2007 at 6:00 PM.<br><br>The psychological assessment dated January 2007 that was reviewed on May 23, 2007 at 3:45 PM reflected that the client should be encouraged to participate in sensory activities including sound, smell, tast, and touch. Further stated was the "it would be helpful to tailor activities around her senses".<br><br>On May 23, 2007 at 4:03 AM, the House Manager indicated that sensory motor equipment was in the facility. The equipment shown included a sensi- ball switch, vibrating mini bubbles, gooshy switch, oval tax multi sensory, and high music vibration enabling device. These | {I 420} | I420<br>1. Client #2's IPP has, since survey, been reviewed with staff such that the program plan for "expressive language skills" will be implemented on a continuous basis. QMRP will ensure staff receive quarterly training on all individuals' IPP to promote continuous active treatment process within the facility.<br><br>2. Client#2's Sensory stimulation program, since survey, has been reviewed with the staff. QMRP has in-services staff on proper implementation of this particular program to include affording Client #2 the opportunity to engage in multi-sensory stimulation activities of her liking and that will enhance her other sensory skills. | 7/6/07 & Ongoing<br><br>7/6/07 & ongoing |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {I 420} | Continued From page 13<br>items were inoperable perhaps due to having no batteries.<br><br>Although music played while all clients were sitting out on their porch, this was the only sensory motor functioning activity provided during the observation. It could not be determined that client #2 had been engaged in the multiple sensory task/activities as recommended.<br><br>3. Client #2's IPP and data was reviewed on May 24, 2007 at approximately 11:00 AM.<br><br>a. Client #2 had an objective which read "will participate in an activity with her peers or staff with verbal assistance". The focus of the program was identified to be "setting the table". There was no opportunity offered or attempted during May 22, 2007 dinner meal or the snack times on May 22 and 23, 2007. The documentation that was reviewed reflected that the client had performed at 0% since January 2007.<br><br>b. Client #2's had an objective to "stack utensils on top of her plate ". There was no opportunity offered or attempted during May 22, 2007 dinner meal or the snack times on May 22 and 23, 2007.<br><br>**********<br>**********<br><br>Based on observation, staff interviews and record review, the facility failed to ensure that residents were provided the opportunities for continuous active treatment in accordance with their individual program plans (IPPs).<br><br>The finding includes: | {I 420} | 3. a) Client #2's program objective that reads "will participate in activity with peers and staff has been revised to reflect proper goal of "participating in an community integration activity of her choice". QMRP will ensure that program objectives are in alignment with program goals reflected in the IPP. All in-service trainings will be provided to staff to ensure proper implementation.<br><br>b) Client#2 has been offered the opportunity to "stack utensils on top of her plate" during mealtimes. QMRP has, since survey, in-serviced staff on implementation of IPP goals and objectives. Continuous active treatment training will be provided quarterly for staff to be kept abreast of any changes or revisions in clients' program plan.<br><br>Home Manager has been in-serviced on maintaining adaptive equipment in good repair and reviewing Adaptive Equipment Checklist that staff complete weekly to ensure for example that Resident #2 has batteries to operate her sensory motor equipment. QMRP will ensure that Home Manager has checked all adaptive equipment for sensory motor activities are maintained in good repair per consultant recommendations. | 7/5/07<br><br>7/6/07 & ongoing<br><br>7/5/07 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G211 | A. BUILDING _____ B. WING _____ | R 07/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HRDI OF THE DISTRICT OF COLUMBIA, LLC | 3073 VISTA STREET, NE WASHINGTON, DC 20018 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {I 420} | Continued From page 14<br><br>On July 5, 2007 at 1:35 PM, the House Manager indicated that the sensory motor equipment in the facility did not contain batteries. Interview with the Quality Assurance Director on July 5, 2007 at approximately 2:00 PM revealed that the facility was ordering new sensory motor equipment along with batteries on July 5, 2007. There was no evidence that Resident #2 had been engaged in the multiple sensory task/activities as recommended by the psychologist. | {I 420} | | |